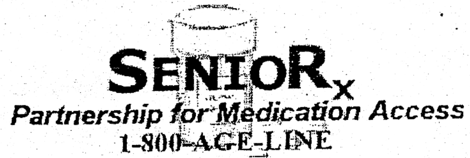

PATIENT CONSENT AND RELEASE FORM

EXCHANGE OF INFORMATION

I give my permission to authorized representatives of the Senior Rx to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize the Senior Rx to discuss my medical needs and me with my physician when necessary. Additionally, I give the Senior Rx permission to verify my income through the Department of Human Resources, Social Security Administration, my employer, Veterans Administration, or any other company, business, or organization from which I receive income.
This authorization is good as long as the Senior Rx is assisting me or I revoke such.

I want a copy of this form to be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

DOB:_______________________ **SSN:**_________________________

ADDRESS:____

FULL PRINTED NAME OF PATIENT: _________________________

SIGNATURE:_________________________ **DATE:**_______________

****

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of the Senior Rx Foundation to sign forms on my behalf for the purpose of soliciting medications through patient assistance programs. This signature authorization is good as long as the Senior Rx is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: _________________________

SIGNATURE: _________________________ **DATE:** _______________

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Interfaith Ministries SenioRx Program	P.O. Box 1444, Anniston, AL 36202

I want this information released because:
I am applying for assistance with my prescription medications.

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_X_ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from __________ to __________
_____ Information about my Medicare claim/coverage from __________ to __________
(specify) ____________________
_____ Medical Records
_____ Record(s) from my file (specify) ____________________
_____ Other (specify) ____________________

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and May be sent to prison, or may face other penalties, or both.

Signature: ______________________________
(Show signatures, names, and addresses of two people if signed by mark.)

Date: __________________ Relationship: __________________

Form SSA-3288 (3-2005) EF (3-2005)